Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities

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OBJECTIVES There are significant health disparities according to sexual orientation and gender identity, particularly in mental health; however, very few mental health professionals specialise in caring for lesbian, gay, bisexual and transgender (LGBT) communities. The purpose of this study was to explore how providers with LGBT-focused practices have developed their capacity for working with these populations.

METHODS Eight semi-structured interviews were conducted with practising mental health service providers with extensive experience serving LGBT individuals. Participants represented four professional disciplines: psychiatry ($n = 2$); social work ($n = 3$); psychotherapy ($n = 2$), and psychology ($n = 1$). The data were analysed for themes that were identified using a descriptive phenomenological approach.

RESULTS All providers self-identified as members of LGBT communities; however, most agreed that this membership was not necessary to provide supportive, appropriate care for LGBT individuals. Providers described their self-identity as members of LGBT communities, associated lived experiences and recognition of the need for mental health services that are sensitive to the unique needs of LGBT individuals as influential factors in their career decisions. The lack of training opportunities and resources specific to the provision of LGBT-sensitive mental health services was highlighted. Provider recommendations included the introduction of mandatory LGBT health content in education curricula that addresses basic LGBT-related terminology, appropriate interview questions to facilitate the disclosure of sexual orientation and gender identity, information regarding the health impact of heterosexism and homophobia, and specific health care needs of sexual and gender identity minority people.

CONCLUSIONS Data from this study suggest there are few opportunities for medical providers to access training and gain expertise in the provision of care to LGBT people. Additional research is needed to consider whether the lack of LGBT health content in medical and psychiatric training programme curricula indirectly contributes to the health disparities experienced by these populations.

Medical Education 2012: ***46****: 903–913*
doi:10.1111/j.1365-2923.2012.04272.x

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INTRODUCTION

Studies have consistently demonstrated that sexual and gender minority people, including lesbian, gay, bisexual and transgender (LGBT) individuals, experience poorer mental health outcomes compared with heterosexual and cisgendered (non-trans) people.[1–3] A recent meta-analysis pooled findings from 25 studies, referring to almost 12 000 lesbian, gay or bisexual individuals, and found that sexual minority individuals have a 1.5 times higher risk for depression and anxiety disorders and are 2.5 times more likely to have attempted suicide than their heterosexual counterparts.[4] Although there are fewer data on transgender populations, the available research suggests that minority gender identities are also associated with disparities in mental health status.[5,6] For example, studies have estimated that 26–43% of transgender individuals have attempted suicide at least once.[5,7–9]

There is evidence indicating that the poor mental health outcomes observed in LGBT communities are associated with the stress of having a stigmatised identity, experiences and expectations of discrimination, and living in a homophobic or heterosexist environment.[10–12] A 2001 study of 2844 people found that the odds of having a psychiatric disorder were significantly increased in individuals who reported any lifetime discriminatory event or day-to-day experiences of discrimination.[13] The study also showed that individuals who self-identified as lesbian, gay or bisexual were significantly more likely than those who identified as heterosexual to report experiencing discrimination across several domains. Adjusting for experiences of discrimination significantly attenuated the relationship between sexual orientation and psychiatric illness, suggesting that it is the experience of discrimination rather than an individual's sexual orientation that negatively impacts the mental health of members of sexual minority groups.

As would be expected in the context of these high rates of need, gay and lesbian individuals are also more likely than their heterosexual counterparts to utilise mental health services.[14,15] Despite high rates of service utilisation, at least one study has found that sexual minorities report higher levels of dissatisfaction with mental health services than do heterosexuals (18% versus 8%).[1] This dissatisfaction may be related to experiences of discrimination in the context of care.[15,16] For example, one study of 6540 transgender individuals found that 28% of participants had experienced verbal harassment in a doctor's office and 19% reported being refused medical care altogether because of their transgender status.[9] In addition to experiences of discrimination, study participants described significant gaps in the knowledge of their health care providers and half of the participant group reported having to teach their providers about some aspect of their health needs as transgender individuals.[9]

These poor health care experiences must be understood in the context of the historical pathologisation of 'homosexual' attractions and behaviours by the American Psychiatric Association (APA).[17] Until 1973, the diagnosis of homosexuality was included in the APA's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and 'ego-dystonic homosexuality' was classified as a mental disorder in the DSM until as recently as 1986. Notably, gender identity disorder continues to be listed as a psychiatric diagnosis in the current edition of the DSM.[18] However, there have been significant shifts in the medical establishment's understanding of sexual and gender minority people over time. In February 2010, the American Medical Association (AMA) released a statement to the Institute of Medicine with respect to the health disparities experienced by the LGBT communities. It called, in part, for the widespread inclusion of LGBT health in medical education curricula, stating that 'Absent explicit teaching [on LGBT issues], there is evidence that physicians and medical students reflect the level of homophobia and heterosexism of the society at large'.[19]

Research published over the past two decades, however, indicates that explicit teaching on LGBT health is either not occurring or, at least, is not achieving widespread curricular integration at either the undergraduate or postgraduate level of medical training.[20–24] A recent survey of deans of medical education at 132 medical schools across the USA and Canada reported overall dissatisfaction with the coverage of LGBT health in the curriculum: 36% of respondents rated the content as only 'fair' and an additional 34% rated it as 'poor' or 'very poor' at their institutions.[23] The challenges associated with integrating LGBT content in medical curricula may stem from the lack of empirical research on this topic; only a handful of studies evaluating the effectiveness of LGBT health education initiatives have been published.[25–27]

The few existing studies, however, show promising results. A 3-hour seminar course implemented at Rhode Island Hospital resulted in almost all of the

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23 participating students reporting that they felt more prepared to care for lesbian and gay patients.[26] Notably, the care of bisexual or transgender individuals was not addressed in this seminar. Similarly, following the introduction of an LGBT health curriculum (composed of an introductory syllabus, patient panels and small-group learning) at the University of California San Francisco (UCSF) in 2004, over 90% of students surveyed reported improved knowledge of LGBT issues.[27] Both of these studies reported that the curricula were well received by students. The effect of LGBT health curricula on students' attitudes towards LGBT individuals has also been studied.[25,27] For example, the UCSF study cited earlier reported that the LGBT curriculum significantly increased the willingness of medical students to care for people with gender identity issues.[27]

Given the status of existing research, there remain a number of important questions regarding how best to improve medical education with respect to the health needs, particularly the mental health needs, of sexual and gender minority communities. One potential source of information is service providers with expertise in the provision of mental health care to LGBT people. In this study, we draw from a recent qualitative study of LGBT-identified mental health service providers with a dedicated LGBT practice focus in order to examine: (i) the factors that led to their specialisation in mental health care for LGBT individuals, and (ii) how these 'experts' have developed their capacity to work with these populations. We also explore how the knowledge and experience these providers have acquired may be used to inform the development of medical education curricular initiatives.

METHODS

This qualitative research study employed a descriptive phenomenological approach, underpinned by social constructionism theory. A phenomenological analysis aims to describe the common elements of the lived experiences of a phenomenon, in this case health care providers' development of expertise in LGBT mental health.[28] This goal was achieved by identifying and organising descriptions of participants' experiences into discrete categories that represent an aggregated process of developing LGBT mental health expertise. Social constructionism emphasises the importance of cultural, social, historical and political factors in understanding social events, processes and experiences, including the production of knowledge (i.e. expertise).[29] The underpinning of social constructionism is significant to the analysis of participants' experiences in that descriptions of the development of LGBT mental health expertise are contextualised by community membership and self-identity (social factors), professional education programmes (cultural factors) and recognised need for LGBT-sensitive services (historical and political factors). Thus, the social construct of LGBT mental health expertise is understood as shifting in response to the influence of particular socio-political moments experienced by participants.

Participants

A total of eight mental health service providers were identified with the aid of the service provider database of Rainbow Health Ontario, a province-wide programme that works to promote health and improve access to care for LGBT communities. Inclusion criteria required that a potential participant: (i) be a practising mental health care professional; (ii) have a minimum of 2 years of experience in working with sexual and gender minorities in the context of mental health services, and (iii) be proficient in English. Although the study sought to capture data from geographically diverse regions of the province, no providers meeting the inclusion criteria could be identified outside the Greater Toronto Area and one additional nearby city. All eight invited providers agreed to participate in the study and signed a written consent form. The study was approved by the Research Ethics Board at the Centre for Addiction and Mental Health (Toronto, ON, Canada).

Among the participants, four professional disciplines were represented: psychiatry ($n = 2$); social work ($n = 3$); psychotherapy ($n = 2$), and psychology ($n = 1$). Five of the participants identified as female and three identified as male (including one trans man [Table 1]). Participants reported their sexual orientations as gay ($n = 2$), lesbian ($n = 1$), bisexual ($n = 1$) and queer ($n = 4$). No participant self-identified as heterosexual. The mean age of participants was 44.4 years; their mean time in practice was 12.8 years. Providers practised in a number of different settings, including community-based programmes, community health centres, private practices, university-based practices and hospital in-patient and out-patient settings.

Data collection

Eight one-to-one, semi-structured interviews were conducted by one of the authors during December

*Table 1 Glossary of key terms**

Bisexual	An individual whose sexual orientation is towards individuals of more than one gender
Cisgender	An individual whose gender identity is consistent with the social expectations and norms associated with his or her assigned sex (i.e. someone who is not transgender)
Gender identity	An individual's sense of self, related to social roles and norms associated with assigned sex (e.g. masculine, feminine, other gendered)
Heterosexism	The institutional norms and behaviours that result from the assumption that all people are or should be heterosexual. The system of oppression that assumes that heterosexuality is inherently normal and superior
Homophobia	The fear and hatred of, negative attitudes towards or discomfort with people who love and sexually desire people of the same sex
Lesbian/gay	Terms to describe individuals whose primary sexual orientation is to members of the same sex. The term 'gay' is sometimes used to refer to both men and women, although many women prefer the term 'lesbian'
LGBT	An acronym for lesbian, gay, bisexual and transgender
Trans man	An individual who was identified as female at birth, but who now identifies and presents as male
Trans woman	An individual who was identified as male at birth, but who now identifies and presents as female
Transgender	A term for someone whose gender identity differs from that associated with his or her assigned sex, and who may not embrace binary gender norms of masculine and feminine. As they do not necessarily experience bodily alienation in the same way, or to the same degree, as transsexual people do, those who identify as transgender often choose not to medically alter their bodies
Transsexual	An individual who identifies as a sex other than that assigned at birth. Some transsexuals undergo surgery or hormone therapy to make their body reflect their sense of themselves
Queer	Originally a derogatory term for a gay man; recently reclaimed by some as an inclusive word for all those within the sexual and gender identity minority communities

* Adapted from Barbara[33]

2009 and January 2010. Interviews ranged between 45 minutes and 75 minutes in length (mean: 60 minutes) and all were conducted at participants' places of work. The interviewer used a flexible interview guide that included questions related to the provider's background and formal training experiences, the perceived barriers and facilitating factors that members of LGBT communities face when they try to access supportive mental health services (results are presented in another paper, recently accepted for publication [J. McIntyre, A. Daley, K. Rutherford, L. E. Ross, unpublished manuscript, 2011]), and provider recommendations regarding the provision of mental health services to LGBT people. The following two questions in particular were drawn upon in addressing our research questions: 'Please describe your practice and how you came to have a focus on working with LGBT communities', and 'Have you done any specific training or learning to help you develop your practice in this area?' All interviews were recorded using a digital recording device and transcribed verbatim by the interviewer. Identifying features were removed during the transcription process and participants were assigned pseudonyms to maintain anonymity.

Data analysis

The data were analysed for themes using a descriptive phenomenological approach.[28] Data were coded using a collaborative iterative process. First, all eight transcripts were read by two independent researchers (the first and second authors). Content analysis and discussion of the identified themes with research team members and colleagues led to the development of a preliminary thematic framework and initial coding structure. The thematic framework was revised through discussion and debate in a process that included ongoing comparisons of transcripts and explorations of individual data examples within the context of the larger emerging themes. The resulting coding structure was formalised into a code book, complete with clear definitions of each theme and sub-theme. Each transcript was then coded by two independent researchers with the aid of NVivo

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qualitative data analysis software (Version 8; QSR International Pty Ltd, Doncaster, Vic, Australia). The researchers then met to review and discuss any differences in coding and to negotiate a final, unified coded dataset. Following the coding procedure, data collected under each code were reviewed and summarised in an analytic memo capturing the major issues present.

RESULTS

Themes identified during data analysis are presented according to the two main research questions: (i) How did providers come to focus on the mental health of LGBT individuals? (ii) How did they develop their capacity to serve these populations and acquire expertise in the field? A section presenting provider recommendations inspired by these questions follows. Figure 1 schematically represents the results of the study, showing the relationships between the two main research questions and the themes identified, namely: LGBT self-identity; the need for LGBT-sensitive mental health services; the inadequacy of available training, and the development of LGBT mental health training programmes.

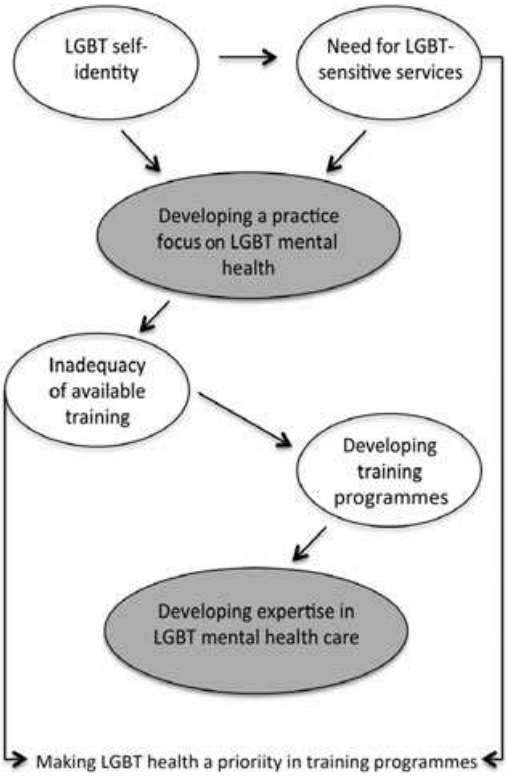

Figure 1 Schematic representation of the results of data analysis. LGBT = lesbian, gay, bisexual and transgender

Developing a practice focus on LGBT mental health

LGBT self-identity

All providers interviewed identified themselves as members of LGBT groups. Although heterosexual service providers were also eligible to participate, we were unable to identify any who met our inclusion criteria with respect to expertise in working with LGBT communities. Providers' reflections on their own LGBT identities and coming out processes underscored the influence their connection to the community and personal experiences had had on their career choices. Miguel, a psychiatrist, described how he sought out a role at an AIDS (acquired immune deficiency syndrome) service organisation as a way of gaining volunteer experience relevant to his career goals while developing more familiarity with local LGBT communities for personal reasons. Philip, a social worker, similarly described the importance of his early life experiences as a young gay man in determining his career pathway:

> 'I was living on the streets of [city] for about 2 years as a young little queer runaway type deal. And I think it was the fact that social workers actually met me and it was through them and social services in [city] at the time that I got my life together… So, that first connection with social workers and counsellors really shaped why I went into the field.' (Philip, social worker)

Providers offered insights into the relative importance of provider–client matching in terms of sexual orientation and gender identity, pointing to benefits and drawbacks in terms of patient care. Benefits afforded by a shared LGBT identity included personal knowledge of the unique issues facing LGBT communities and increased ease in creating a safe space for the disclosure and discussion of sexual orientation and gender identity:

> 'Referrals [to me] ended up being people who happen to have a mental health problem and happen to also be lesbian or gay and are looking for someone – or wanted a referral to someone – who they felt would be friendly. Because of course a lot of people, especially older members of the LGBT community, have had negative previous experiences with the mental health services.' (Miguel, psychiatrist)

However, providers pointed out the vast diversity of identities encompassed by the LGBT umbrella, noting, for example, that having a lesbian identity does

not *a priori* afford knowledge and insight into the experience of a trans man. Participants also emphasised the need for additional learning and ongoing training, even for LGBT-identified providers.

By contrast, some providers noted that it can be detrimental to patient care if LGBT-identified providers assume that a client's experience of his or her sexual orientation or gender identity is similar to their own:

> 'You have to be careful when you are gay or lesbian yourself that you're not automatically assuming that what they think about their sexual orientation is consistent with what you think. So you have to explore what the meaning is to them if you want to help them.' (Miguel, psychiatrist)

Providers also described a potential negative personal impact of a shared LGBT identity:

> 'I can't ever go to a party, a bar, a political gathering, any kind of event without seeing clients, former clients… so it's a very, very public role which can be really tricky to negotiate.' (Alak, psychotherapist)

In considering the relative importance of provider sexual orientation or gender identity, providers emphasised that there are simply not enough trained professionals within the LGBT community to meet the current demand for services. Ultimately, however, there was also consensus that it is not necessary to identify as LGBT to be able to provide supportive quality care to gender and sexual minority patients:

> 'I don't think you need to identify as part of a marginalised community in order to be helpful for that community, but you sure have to have done your work… You need to unpack your own biases and [do] a lot of work on self-reflection and evaluation and education that never stops.' (Tamara, psychologist)

Tamara elaborated with a personal example. Although she is not trans, she has worked to make her practice trans-positive and is now considered a good ally to the transexual and transgender communities.

Recognition of the need for LGBT-sensitive services

Providers overwhelmingly stressed that there is a lack of mental health services that are sensitive and responsive to the needs of LGBT individuals:

> 'There [are] tremendous shortages of knowledgeable, skilful people. What we really need is we need to train more social workers, psychotherapists, psychologists and psychiatrists desperately.' (Alak, psychotherapist)

Recognising this deficiency, a number of providers described being motivated to enter a certain professional discipline, seek out job opportunities with an explicit LGBT component, or assist with the development and implementation of LGBT-specific programmes:

> 'We really worked hard to get kind of separate space and also just the ability to call ourselves an LGBT programme or team. There was a lot of resistance to that initially and often that's the case with oppressed groups.' (Susan, psychotherapist)

In particular, both of the psychiatrists interviewed described having identified substantial need for competent psychiatry services in the LGBT community during their residency training. As members of the LGBT community, they reported having felt a personal responsibility to address this deficiency upon graduation:

> 'I graduated [recently]… and knew that there was a sore lacking of services for the LGBT community here in [city] and, in being part of the community myself, wanted to hopefully change that.' (Leah, psychiatrist)

> 'I had this sense that when I graduated I wanted to do something for the community because of being aware of the issues around access for competent LGBT mental health care. And so I approached the chief at [hospital] at that time when I was looking for work and about wanting to start an LGBT consultation service.' (Miguel, psychiatrist)

Developing expertise in LGBT mental health care

Inadequacy of available training

All providers emphasised the lack of available resources and professional training opportunities to specifically address the mental health needs of LGBT individuals:

> 'There hasn't been a lot of LGBT-specific training, which has been the challenge [for people working in this field].' (Jamila, social worker)

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Most providers had attended workshops and conferences with LGBT-specific content, or had completed educational rotations in LGBT care. However, providers emphasised that these were opportunities they had actively sought out, rather than being standard or mandatory components of their training programmes. Providers frequently cited 'on the job' learning and 'picking things up' as they went along as a large component of their 'training' in mental health service provision for LGBT individuals:

> 'It started with me understanding myself a little bit better while working with the clients, getting more knowledge and education as I went along.' (Priya, social worker)

With respect to formal education and mandatory curricula, providers, other than one provider trained in social work, generally felt that LGBT content was lacking. The inadequacy of LGBT health content and coverage in education curricula was most strongly underlined by the psychiatrists, both of whom were recent graduates:

> 'A lot of folks have said to me that they feel that there is a lack of training in this particular area for mental health people and I would agree that that's true, having just completed my training not that long ago. I can tell you that there really wasn't so much LGBT focus at any point in my training, whether it be medical school or residency training.' (Miguel, psychiatrist)

Leah emphasised that simply including LGBT content was not sufficient, and that medical educators need to ensure that they avoid perpetrating potentially harmful stereotypes about LGBT people:

> 'In medical school we had really no exposure to LGBT issues, and the only way that we did was in a very stereotypic kind of way… there was a case of the young man with HIV [human immunodeficiency virus] who was gay – of course he was. And then the lesbian that we had was allergic to her cats. So it was very stereotypical. And I mean, I laugh about it now … because I am part of the community and can see how stereotypical that is, but for someone who's maybe not part of the community they may think that that's a fair representation of the community and we all know from our part in the community that it's not.' (Leah, psychiatrist)

A social work professor, by contrast, described a positive shift in both the attitude and curriculum content of social work education since he had graduated:

> '[There] wasn't so much in my day. In my day we were lucky if someone put it in or if we suggested it they put it in, but it wasn't sort of a mandatory no-brainer. Today it's a mandatory no-brainer; every course syllabus in our faculty has queer content. Period. And I think that's due to a lot of the work and the advocacy that people did.' (Philip, social worker)

Developing training programmes

In recognition of the substantial need for LGBT-sensitive mental health services, as well as the lack of available training opportunities, many providers had taken it upon themselves to try to address this gap by developing workshops and training materials, either independently or by carving out roles in this respect as part of their work in LGBT-mandated organisations. For example, Priya, a social worker, described how she had applied what she had learned working with LGBT clients to the development of training materials for other providers within her professional role with an LGBT-focused programme. She went on to highlight the importance of offering these trainings and engaging a variety of audiences in these issues, including other health care professionals, office and support staff:

> 'I think that everybody needs to have some basic training around queer issues… What's the difference between transgender and transsexual? People are trying to wrap their heads around this. People need to know what the words are.' (Priya, social worker)

Identifying an even greater need for LGBT-sensitive services outside of major urban centres, another provider described using his knowledge and experience to build capacity in these areas:

> 'Once you go outside the city of Toronto, I've got to tell you it's pretty bad. I often go and do trainings in the suburbs and hearing people talk about how little is available and how little knowledge there is out there is frankly heartbreaking.' (Alak, psychotherapist)

One psychiatrist described how, despite her desire to contribute to education in the area of LGBT mental health, her interest in training students to conduct LGBT-sensitive psychiatric assessments had been hindered by a lack of support from her hospital and

university. Without hospital support for the establishment of LGBT-specific services, she had had to seek out an alternative space in which to hold a weekly outpatient clinic. She described the impact this has on the level of interest and training opportunities available for students and residents to develop their capacity to work with LGBT communities:

> 'Truthfully, me being in the basement in this office that doesn't look like an office – it doesn't really give legitimacy to the work that I do there… but if there was more funding or support from the university then maybe I could have students there and actually teach students… I think if there was some funding available from the university or the hospital then maybe there would be more people interested in providing [LGBT-specific] services so it's not just me.' (Leah, psychiatrist)

Participant recommendations

Making LGBT health a priority in training programmes

Discussing the lack of available services and the inadequacy of their training experiences prompted many providers to offer recommendations for improving the capacity of the mental health care system to care for LGBT individuals. Foremost among these recommendations was that LGBT content be included in education curricula at a level at which it can reach all mental health professionals, irrespective of practice type or geographical location. They noted that LGBT-specific trainings, workshops and continuing medical education sessions attract providers who have already recognised the importance of LGBT mental health issues and taken the initiative to address their own knowledge gaps, rather than those most in need of training in LGBT issues:

> 'There are continuing education programmes that we're involved in, whether they are conferences, rounds, presentations or other work… I mean that's not going to get the people who aren't interested, because in continuing your medical education you get to pick and choose what you want… In that respect, you need to make sure these issues are at least in the curriculum and training programmes for mental health professionals.' (Miguel, psychiatrist)

Participants also identified specific topic domains that should be included in this mandatory curriculum. These included instruction on the distinctions between sexual orientation, sexual behaviours and gender identity, as well as how to ask about each of these three domains in a diversity-aware and culturally competent manner. A number of providers highlighted the importance of teaching the basic terminology used to describe members of LGBT communities. Both Priya, a social worker, and Susan, a psychotherapist, felt that it is often lack of knowledge or discomfort with the topic that leads providers to omit important questions about sexual orientation and gender identity, or to ask questions in unintentionally heterosexist ways. Jamila, a social worker, described the risks of heterosexist assumptions and the need to create safe spaces:

> 'You hear far too often about health professionals saying, ''Well, we don't have any of those people who are using our service.'' But no-one's going to come out to you [if] they don't feel safe enough to. So what are you going to do on your end to give enough safety for people to come out?' (Jamila, social worker)

One psychiatrist emphasised that the goal is not to make everyone an expert in the field of LGBT mental health, but, rather, to ensure that all providers have a basic understanding of the key issues facing these populations in order to ensure that LGBT individuals receive sensitive, respectful and effective care within mainstream mental health services:

> 'Not everybody needs to be an expert, but people need to have a basic understanding and a basic respect, and I think that would go a long way to provide hopefully a reasonable experience for people so that at least they're not having negative experiences… Right now the unfortunate part is that people really have not had the kinds of education that they really need to have had to feel a level of comfort with [the LGBT] population.' (Leah, psychiatrist)

DISCUSSION

This study highlights the experiences of a sample of LGBT-identified mental health service providers with strong personal and professional ties to LGBT communities, who have overcome the lack of LGBT health content in formal education to develop practices focused on meeting the unique needs of these populations. The findings show that they have developed their capacity to work with sexual and gender identity minority individuals through a combination of personal experience and knowledge, on-the-job training and ongoing participation in workshops, conferences and continuing professional edu-

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cation courses. In addition, many of the providers interviewed have applied their experience and expertise to the development of training programmes for other service providers.

Our data suggest that although all the providers interviewed in this study self-identified as members of LGBT communities, this is not necessary in order for providers to offer sensitive and appropriate mental health services to sexual and gender minority individuals. Many of the benefits providers associated with a matched provider–client LGBT identity, including knowledge of LGBT health issues, an open-minded approach, avoidance of heterosexist assumptions, and creation of an LGBT-positive space, could be accomplished by any practitioner with the appropriate training. Unfortunately, our data also suggest that mental health providers do not receive adequate training in LGBT health as part of their formal education. Providers who had completed medical and psychiatric training in particular reported curricular deficiency in this regard. These findings agree with the results of a recent survey of over 3500 medical students across North America in which 36% of students rated the LGBT curricular content at their institution as 'fair' and 34% rated it as 'poor' or 'very poor'.[24]

This study has a number of limitations that should be noted. We were able to identify only eight service providers who met our inclusion criteria and, as a result, we are unlikely to have achieved thematic saturation. In particular, although the data suggest that training experiences differed among the professional disciplines represented, only two medical graduates, both of whom were psychiatrists, were included. Additional research, both qualitative and quantitative, is needed to understand variations in training associated with different professional disciplines. Another potential limitation is that all of the eight providers interviewed self-identified as members of LGBT communities, which may limit the transferability of the results. Unfortunately, there is no literature examining this issue in a non-LGBT group of practitioners, probably because so few non-LGBT practitioners consider themselves to have mental health expertise in this area. These limitations indicate a need to conduct further research in order to ensure that all themes are explored fully and to include the perspectives of heterosexual and cisgender (Table 1) providers working with LGBT communities. The geographic clustering of participants in urban southern Ontario may limit the application of findings derived from these participants in other regions; however, we believe that our inability to identify any providers in other regions of Ontario who considered themselves expert in LGBT mental health speaks strongly of the greater need for improved training for all providers in order to reach these areas.

This study has a number of implications for medical education. Firstly, inclusion of a mandatory LGBT component in education curricula is the only way to ensure that all graduates entering the mental health field have had, at minimum, exposure to the basic terminology, key issues and important considerations necessary to provide quality care and develop comfort working with LGBT individuals. With respect to medical education, although data are limited, available studies indicate that these sorts of curricular initiatives can be effective.[26,27] It should be noted, however, that the available studies have been carried out at relatively liberal institutions; further research is urgently needed to determine how such initiatives will be received in more conservative locales, as well as which LGBT curriculum inclusion modalities will be most effective. Secondly, the data underscore the importance of faculty staff and institutional support for the development and successful implementation of these curricula. In a recent survey of 132 medical education deans, 67% reported 'faculty willing and able to teach LGBT-related curricular content' as a strategy that is currently or potentially successful in increasing LGBT-related content in curricula, and only 35% felt that increased financial resources were needed to do so.[23]

In developing and implementing LGBT health curricula, educators should address the impacts of heterosexism, homophobia and other forms of discrimination on the health of LGBT individuals, and avoid adding content that serves to perpetuate unhelpful stereotypes of LGBT people, as described in our research. A study conducted in 2000 suggests this is not an isolated finding and cites stereotypical depictions of LGBT individuals in case-based learning reported by gay and lesbian doctors in training.[30] Medical educators must also strive to ensure that the health care needs of all sexual and gender identity minorities are equally addressed by curricular reforms. A 2002 survey of medical residents' experiences of medical education revealed that although 40% felt they had received inadequate education on gay men's health, 68% reported inadequate educational coverage of lesbian health issues.[31] Notably, this study failed to include any questions about bisexual or transgender health issues.

Collaborations among medical and psychiatric training programmes, and providers, organisations and other health care disciplines with extensive experi-

ence in providing care for LGBT communities would facilitate the development of high-quality, comprehensive curricula that will equip trainees with the knowledge they require to address the needs of these unique and diverse populations. To develop education curricula, medical schools could draw upon the knowledge and experience of those within their communities who, like our participants, have used their knowledge and experience in working with LGBT individuals to develop training programmes or educational material. They should also offer professional development opportunities for faculty staff. Table 2 summarises our recommendations for medical educators regarding the inclusion of LGBT-related content in curricula. Data from this study, together with the findings of other work in this field,[15,21,22,27,32] suggest that if LGBT health content is not introduced into medical and psychiatric training programme curricula, we will continue to fail to meet the health care needs of LGBT individuals and will thus perpetuate the health disparities experienced by these populations.

In conclusion, this study supports a recent statement by the AMA calling for the widespread integration of LGBT health content into medical curricula in order to prepare all medical professionals, regardless of future discipline or region of practice, to provide sensitive, quality care that meets the needs of all their patients, including sexual and gender minority individuals.[19] Without such inclusion, the medical community risks continuing to contribute to the mental health disparities experienced by LGBT communities.

Table 2 Recommendations for integrating lesbian, gay, bisexual and transgender (LGBT) health into medical curricula

Curricular content
A lecture on health disparities in LGBT communities
A lecture or small-group discussions on LGBT terminology and interview skills
Case presentations involving LGBT patients
Standardised patients who identify as LGBT
Panel presentations with LGBT-identified patients
Clinical rotations or electives with a focus on LGBT health
Invited speakers with expertise and experience in caring for LGBT patients
Curricular development
Identification and involvement of supportive faculty staff at the institution
Identification and partnership with local community resources
Professional development opportunities for faculty staff

Contributors: KR substantially contributed to the thematic analysis and interpretation of data and to the development of the thematic framework, literature review and drafting of the article. JM and LER made substantial contributions to the study conception and design, and to the acquisition, analysis and interpretation of data. AD made substantial contributions to the study conception and design, and to the analysis and interpretation of data. All authors contributed to the critical revision of the article and approved the final manuscript for publication.

Acknowledgements: the authors would like to acknowledge the contributions of the study participants, as well as the support and contributions of Dr. Elise Paradis. Additional support to the Centre for Addiction and Mental Health (CAMH) for the salaries of scientists and infrastructure has been provided by the Ontario Ministry of Health and Long Term Care. The views expressed here do not necessarily reflect those of the Ministry of Health and Long Term Care.

Funding: KR received funding for this research through a Health Professional Student Research Award from the Canadian Institutes of Health Research (CIHR). LER is supported by a New Investigator Award from the CIHR and the Ontario Women's Health Council (Award NOW-84656). Additional funding was received from the CIHR, the Institute of Gender and Health (IGH), and from Fonds Québécois de Recherche sur la Société et la Culture to the Sexual and Gender Diversity: Vulnerability and Resilience Research Group.

Conflicts of interest: none.

Ethical approval: this study was approved by the Ethics Review Board of the Center for Addiction and Mental Health.

REFERENCES

1 Avery AM, Hellman RE, Sudderth LK. Satisfaction with mental health services among sexual minorities with major mental illness. *Am J Public Health* 2001;**91** (6):990–1.

2 Cochran SD, Mays VM. Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: results from the California Quality of Life Survey. *Am J Public Health* 2007;**97** (11):2048–55.

3 Diamant AL, Wold C. Sexual orientation and variation in physical and mental health status among women. *J Womens Health* 2003;**12** (1):41–9.

4 King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, Nazareth I. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008;**8**:70.

5 Clements-Nolle K, Marx R. HIV prevalence, risk behaviours, health care use, and mental health

status of transgender persons: implications for public health intervention. *Am J Public Health* 2001;**91** (6):915–21.
6 Burgess D, Lee R, Tran A, van Ryn M. Effects of perceived discrimination on mental health and mental health services utilisation among gay, lesbian, bisexual and transgender persons. *J LGBT Health Res* 2007;**3** (4):1–14.
7 Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviours. *Suicide Life Threat Behav* 2007;**37** (5):527–37.
8 Scanlon K, Travers R, Coleman R, Bauer G, Boyce M. Ontario's trans communities and suicide: transphobia is bad for our health. *Trans PULSE E-Bull* 2010;**1** (2):1–2.
9 Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force 2011. http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf. [Accessed 19 March 2012]
10 Meyer IH. Prejudice and discrimination as social stressors. In: Meyer I, Northbridge M, eds. *The Health of Sexual Minorities*. New York, NY: Springer 2007;242–67.
11 Grella CE, Greenwell L, Mays VM, Cochran SD. Influence of gender, sexual orientation, and need on treatment utilisation for substance use and mental disorders: findings from the California Quality of Life Survey. *BMC Psychiatry* 2009;**9**:52.
12 Welch S, Collings SC, Howden-Chapman P. Lesbians in New Zealand: their mental health and satisfaction with mental health services. *Aust N Z J Psychiatry* 2000;**34** (2):256–63.
13 Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *Am J Public Health* 2001;**91** (11):1869–76.
14 Tjepkema M. Health care use among gay, lesbian and bisexual Canadians. *Health Rep* 2008;**19** (1):53–64.
15 Beehler GP. Health care needs of gay men and lesbians in the United States. Council on Scientific Affairs, American Medical Association. *JAMA* 1996;**275** (17):1354–9.
16 Beehler GP. Original research: confronting the culture of medicine: gay men's experiences with primary care physicians. *J Gay Lesbian Med Assoc* 2001;**5** (4): 135–41.
17 Stein TS. Overview of new developments in understanding homosexuality. In: Oldham J, Riba M, Tasman A, eds. *Review of Psychiatry*. Washington, DC: American Psychiatric Press 1993;9–40.
18 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (Revised), 4th edn. Washington, DC: American Psychiatric Publishing 2000.
19 American Medical Association. Statement of the American Medical Association to the Institute of Medicine. Re: lesbian, gay, bisexual and transgender (LGBT) health issues and research gaps and opportunities: Institute of Medicine hearing on LGBT health issues. 1 February 2010. http://www.ama-assn.org/resources/doc/rfs/ama_statement_to_iom_on_020110.pdf. [Accessed 19 March 2012.]
20 Wallick MM, Cambre KM, Townsend MH. How the topic of homosexuality is taught at US medical schools. *Acad Med* 1992;**67** (9):601–3.
21 Tesar CM, Rovi SL. Survey of curriculum on homosexuality/bisexuality in departments of family medicine. *Fam Med* 1998;**30** (4):283–7.
22 Robb N. Medical schools seek to overcome 'invisibility' of gay patients, gay issues in curriculum. *CMAJ* 1996;**155** (6):765–70.
23 Obedin-Maliver J, Goldsmith E. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA* 2011;**306** (9):971–7.
24 White W, Wells M. Lesbian, gay, bisexual, and transgender curricular content: medical student experiences and perspectives. 28th Annual Conference of the Gay and Lesbian Medical Association, 22–25 September 2010, San Diego, CA.
25 Wallick MM, Cambre KM, Townsend MH. Influence of a freshman-year panel presentation on medical students' attitudes toward homosexuality. *Acad Med* 1995;**70** (9):839–41.
26 McGarry K, Clarke J, Cyr MG. Enhancing residents' cultural competence through a lesbian and gay health curriculum. *Acad Med* 2000;**75** (5):515.
27 Kelley L, Chou CL, Dibble SL, Robertson PA. A critical intervention in lesbian, gay, bisexual, and transgender health: knowledge and attitude outcomes among second-year medical students. *Teach Learn Med* 2008;**20** (3):248–53.
28 Starks H, Trinidad SB. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qual Health Res* 2007;**17** (10):1372–80.
29 Kitzinger C, D'Augelli A, Patterson C. Social constructionism: implications for lesbian and gay psychology. In: D'Augelli A, Patterson C, eds. *Lesbian, Gay and Bisexual Identities over the Lifespan*. New York, NY: Oxford University Press 1995;136–62.
30 Risdon C, Cook D, Willms D. Gay and lesbian physicians in training: a qualitative study. *CMAJ* 2000;**162** (3):331–4.
31 McGarry KA, Clarke JG, Cyr MG, Landau C. Evaluating a lesbian and gay health care curriculum. *Teach Learn Med* 2002;**14** (4):244–8.
32 Lock J. Strategies for reducing homophobia during medical training. *J Gay Lesbian Med Assoc* 1998;**2** (4):167–74.
33 Barbara AM. Asking the Right Questions. 2: Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings. Toronto, ON: Center for Addiction and Mental Health 2004.

Received 20 July 2011; editorial comments to authors 12 October 2011, 23 December 2011; accepted for publication 9 February 2012